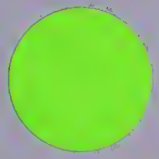
A REVIEW OF STATE TASK FORCE AND SPECIAL STUDY RECOMMENDATIONS TO ADDRESS HEALTH CARE FOR THE INDIGENT

Compiled by

STATE MEDICAID INFORMATION CENTER
National Governors' Association
Center For Policy Research

and



INTERGOVERNMENTAL HEALTH POLICY PROJECT
George Washington University

A REVIEW OF STATE TASK FORCE AND SPECIAL STUDY RECOMMENDATIONS TO ADDRESS HEALTH CARE FOR THE INDIGENT

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AUTHOR'S NOTE

This document is one of a series of publications intended to meet the needs of state and local policymakers. For further description and analysis of the issues raised in this report, please refer to the following publications:

Access to Care for the Medically Indigent:
A Resource Document for State and Local Officials
The Academy for State and Local Government
444 North Capitol Street, N.W.
Washington, D.C. 20001
202/638-1445
Price: $15.00

This publication provides relevant background information and presents policy options for state and local officials interested in addressing the medically indigent issue. It provides a brief overview of the size and nature of the populations and of health care market and policy trends that are likely to cause increasing problems with access to care for these individuals. An analysis of state laws and judicial decisions provides an overview of national patterns as well as state-by-state information regarding state and local government legal responsibility for financing indigent health care.

Policy options are outlined that can be used at the state and local level to finance and deliver health care for the medically indigent, including examples drawn from case studies. Ten case studies of existing model state and local policies include information on program design, financing mechanisms and populations served, as well as contextual demographic and economic information.

Profiles of State Programs of Assistance to the
Medically Indigent
The Intergovernmental Health Policy Project
Suite 616
2100 Pennsylvania Avenue, N.W.
Washington, D.C. 20001
202/872-1445
Price: $20.00

This report describes the various state and state/county health care programs that may be accessed by the medically indigent. The programs listed are funded within the state, usually by the state and/or county governments. Programs that have matching federal funds, such as Medicaid, are specifically excluded.

In the survey, each state's indigent care program is profiled. The profile includes: indigent care and disease-specific programs; health insurance programs that increase the availability of insurance coverage for indigents, including catastrophic care programs, risk-pools, and continuation/conversion policies; provisions for reimbursing hospital charity care in rate-setting states; and certificate of need provisions that consider indigent access to medical care as part of the approval process. Each program profile contains information on services provided, expenditures, and eligibility requirements. The report will be available in February 1985.

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I. INTRODUCTION

The need to finance and deliver necessary health services to persons without the resources to pay for care has long been a concern of state governments. States have been forced to make very difficult policy choices because the cost of medical care has constantly increased at a rate exceeding that of the increase in state revenues. States are reassessing their indigent care programs because of the convergence of a number of forces.

Cutbacks in federal and state programs (e.g., Aid to Families with Dependent Children) have decreased the number of persons eligible for Medicaid, which is the major source of funding for medical services for the poor. The cost containment initiatives of major purchasers of health care, both public and private, are inducing price competition among providers that reduces their ability to cross-subsidize health services for the poor. As charity patients are increasingly shifted to hospitals serving unusually large indigent populations, these institutions are in increasing fiscal difficulty.

The recent economic recession and higher rates of unemployment have left greater numbers of persons without health insurance coverage. Also, as a result of employers' efforts to contain their own burgeoning health costs, more people may be underinsured and at risk of greater medical expenses. Finally, a number of court decisions have enforced the principle that state and local governments have a legal responsibility to provide medical services to the indigent.

In response to heightened awareness of the indigent care issue, a number of states have established special deliberative bodies, such as Task Forces, Commissions, and Study Groups, to address the problem. This document reviews the analyses and recommendations from a number of states. The information presented in the case studies was gathered in response to surveys of state government officials by the National Governors' Association State Medicaid Information Center (SMIC) and the Intergovernmental Health Policy Project (IHPP). SMIC requested information from governor's offices and Medicaid directors; IHPP contacted state legislative and study committee staff.

This document is not a comprehensive listing of all state activities. Some states did not respond, and some states, responding with information not directly relevant, are not included here. The aim of this publication is to share information about state initiatives to study indigent care — background and purpose, structure of the study, use of data and information to identify the scope of the problem, findings and recommendations, and policy outcomes resulting from the study.

The level of detail provided in the state summaries vary, depending upon the amount of information contained in the survey response, the uniqueness or special nature of the state's efforts, or the preliminary nature of studies currently underway.

II. OVERVIEW

A. Background and Purpose

The Task Forces/Commissions identified in this publication represent a broad range of structures. Some of these groups were appointed by governors; others were established by state legislatures, and still others were organized within or between state executive departments.

In addition to structure, these entities are differentiated by purpose. A number of groups were formed specifically to address the issue of health care for the indigent. Others were established to focus on broader issues (e.g., health care cost containment or welfare reform), but examined indigent care as a collateral issue.

Many of the study groups were charged to, or chose to, address indigent care within the context of health care cost containment. Their aim was to improve access to needed health services, but in a cost-effective manner. The Ohio Commission, for example, assumed that the state would not fund any new initiatives. The Committee in South Carolina worked under the principle that incentives for cost-effective delivery of care should be established.

B. Analysis

1. Problem Definition:

The Task Forces/Commissions established in the states define the indigent care issue in various ways. In general, definitions of the problem can be separated into two groups: those that identify categories of persons experiencing problems in accessing the health care delivery system; and those that are based on the assumption that solutions will come through expanding or modifying the financing of existing services. Within these generic categories, there are subcategories that limit the scope of the definition.

Some study groups chose expansive definitions of the target population that encompassed all persons who do not have the resources to pay for needed health services (e.g. Colorado). Others limited their definitions to poor persons who could be made eligible for an expanded general relief program (e.g. Wisconsin).

Those groups that focused their attention on financing also exhibited variations in their definitions of the scope of financing strategy. For example, Ohio proposed redistributing the indigent care burden among hospitals. Oklahoma, on the other hand, favored increasing public revenues available to reimburse hospitals for indigent care.

It should be noted that the two categories of problem definitions used here are for analytic purposes only. They are not mutually exclusive; most study groups, in fact, framed the problem definition to address both the coverage and financing issues (e.g., Arkansas, Florida and Texas). The categories, however, are useful for separating the study groups on the basis of where the emphasis was placed. The choice of how to define the indigent care problem sets parameters on its analysis and structure the types of recommendations issued by the study groups.

2. Data:

After the indigent care issue was defined, the next step taken by most of the study groups was the compilation of data to identify the demographics of the population at risk and/or the existing programs to finance indigent care. Most of the Task Forces/Commissions referenced national data. A number of states — Colorado, Texas, New Mexico, and Tennessee — analyzed studies or surveys to assess indigent care within the state.

The Colorado Task Force, for example, did an extensive survey of the state's population to determine the prevalence of medical indigency. Results of the survey indicate that certain populations are more apt to lack insurance coverage: racial and ethnic minorities, farm and blue collar occupations, and residents of urban areas. The survey also determined that over 40% of the uninsured population are under age 18 and that 50% of employed persons do not have health insurance. New Mexico compiled data indicating that 21% of its population does not have public or private insurance coverage. Disaggregation of these data suggest that young persons, poor persons, Hispanics, and residents of rural areas are the populations most likely to lack health insurance.

Other study groups estimated the indigent population based on existing data sources. The Arkansas Task Force Report, using data from 1979, determined that only 65% of the non-elderly population of Arkansas were insured as compared to 85%, nationwide.

In addition to identifying the at risk populations, Task Forces/Commissions often tried to gather data concerning the fiscal impact on providers. These efforts focused on measuring costs of indigent care for which providers are not reimbursed, and disaggregating the data by individual hospital characteristics.

Some of the Task Forces analyzed uncompensated care data to separate the proportion that can be attributed to indigent care from to contractual adjustments (the difference between hospital charges and the rate reimbursed by payers) or bad debt. The Arkansas Task Force found that 65% of uncompensated care is attributable to contractual adjustments, while charity care, including Hill-Burton obligations, account for only 7% of the total. These study groups also found that the bulk of uncompensated care is concentrated in a few large facilities, typically public teaching hospitals in urban areas.

Another focus of data gathering was the cataloging of current state programs that fund health care services for the indigent. Study groups often analyzed the Medicaid programs in their states to identify those categories of poor persons who could become eligible for Medicaid and those persons who would be unable to meet the categorical or financial criteria for Medicaid eligibility.

C. Findings and Recommendations

Recommendations issued by the Task Forces/Commissions fall into five major categories:

- Expand Medicaid eligibility on a limited basis, targetting the most vulnerable populations, primarily pregnant women and children, the lowest-cost categories of Medicaid recipients. Most of the states recommending this course currently cover a lower proportion of poor persons under the Medicaid program than the national average. For example, Texas Medicaid enrolls about 25% of the poverty population, compared to 53% nationally.

- Establish or expand state programs for the indigent who are not eligible for federally-funded programs. The Task Force in Utah, for example, recommended that the state assume administration and funding for the existing optional county program. The Georgia Committee suggested that, whenever possible, new funds should be directed to existing public health programs.

- Establish other methods to finance indigent health care. Study groups' recommendations approached this issue in one of two ways. Some state groups (e.g., Ohio and Florida) proposed that hospital resources be redistributed to those hospitals serving a disproportionate number of indigents. Others, (e.g., Oklahoma, Arkansas, Georgia) advocated the establishment of pools funded by the state and/or counties to reimburse hospitals for indigent care. A common element in both approaches, for most study groups, is the requirement that hospitals provide a set minimum amount of indigent care.

- Clarify public responsibility for indigent care. In many states the level of government responsible as the payer of last resort for indigent care is not clearly defined in the state Constitution or statute. The emergence of the indigent care issue has led states and local governments to explicitly address the responsibility question. The state of Washington's Advisory Committee found that responsibility rests with the state. The Wisconsin Advisory Committee chose a mixed approach, determining that funding is a state responsibility, while counties are responsible for administration.

- Define medical indigency. Most study groups recommended that uniform eligibility requirements be established. These requirements typically define medical indigency based on income and resource limits and the lack of any third-party coverage. A number of Task Forces/Commissions linked indigent program eligibility requirements to those for Medicaid or AFDC.

- Develop a major policy and program emphasis on services for children and pregnant women. The Texas Task Force issued a series of recommendations to provide a range of necessary services, develop health promotion activities, emphasize programs to identify and provide care for high-risk pregnancies. The Arkansas Task Force

recommended programs for the regionalization of maternity care and care for children under age five. A regionalized system of obstetrical care would have both service and education components and would treat patients at local primary care centers or through referrals, based on the risk associated with the pregnancy. A regionalized referral system for children would be developed to include a statewide clinic system to serve infants and children on physician referral.

D. Policy Outcomes

It is premature to evaluate the policy outcomes that can be attributed to the work of the Task Forces/Commissions described in this document. Most of the study groups have not yet ended their deliberations. Further, many study group recommendations require legislative action, which cannot take place until the next legislative session. Those policies that have been adopted as a result of the work of Task Forces/Commissions are summarized below:

- afford Medicaid eligibility to targetted groups. Florida and Texas have included as Medicaid eligibles those optional categorical groups of pregnant women, and children under age 18 permitted by federal statute. South Carolina and Florida have adopted limited Medically Needy programs for pregnant women and children.

- establish mechanisms to finance public reimbursement for indigent care. Two states, Oklahoma and South Dakota, enacted legislation creating pools of state and county funds for the purpose of enabling counties to reimburse providers for indigent care.

- establish hospital revenue pools. Florida has established a hospital revenue pool financed by one percent of hospital operating revenues (to increase to one-and-a-half percent in the second year) and through a state appropriation. The fund will be used to finance expansions in Medicaid eligibility and will permit the establishment of primary care case management programs for indigents. In addition, the legislation mandated a study of the feasibility of compensating hospitals providing a disproportionate amount of charity care.

III. STATE SUMMARIES

ARKANSAS

Task Force/Commission

The Governor's Task Force on Indigent Health Care
Date Established: February 1984

Background and Purpose

The Task Force was charged with addressing the problems of health services for the poor. Four separate subcommittees were established to make recommendations on maternal and child health, Medicaid expansion, provider reimbursement, and reform and expansion of private health insurance coverage.

Analysis

The Task Force Report analyzed indigent health care from a number of perspectives, isolating four specific issues that demonstrate the extent of the problem in Arkansas.

- Defining the population in poverty and at risk for indigent care

  Using 1979 data that underestimates the current problem, because it was before the recent recession, 19% of the Arkansas population were below 100% of the poverty level, compared to 12.4% nationwide. The incidence of poverty was more severe for children and the elderly. About 23% of persons under age 18 and 28% of persons 65 years and over had incomes below the federal poverty line.

- Medicaid coverage of the at risk indigent population

  Income eligibility standards for Arkansas Medicaid are extremely low compared to those of other states. For 1982, Arkansas had the fourth lowest AFDC payment standard for a family of four (this was lower than it had been in 1970). The low Arkansas eligibility standards, coupled with federally mandated reductions in eligibles in 1981, resulted in a 14% decrease in the number of Medicaid eligibles between FY 81 and FY 83. The low income eligibility criteria also affects eligibility for the Medically Needy category of the Medicaid program. Of the 30 states with Medically Needy programs in 1982, Arkansas had the second lowest net protected income standard. As a result of these low income eligibility standards and the categorical restrictions for eligibility, it is estimated that the Arkansas Medicaid program covers less than one-third of the poverty population under age 65.

- Population Without Insurance

  Fewer persons in Arkansas are covered by private insurance than is the case nationwide. The Task Force cites health insurance industry data indicating that 65% of Arkansas residents under age 65 had hospital insurance, as compared to 85% for the United States as a whole.

~ Uncompensated Care in Hospitals

Data provided by Arkansas hospitals show that, in their most recent fiscal year, hospitals classified $259.8 million as uncompensated care. When disaggregated, 65% of the uncompensated care revenue is attributed to contractual adjustments, defined as the difference between charges and the rate paid by third parties. Bad debt comprises the next greatest amount, totaling 28% of uncompensated care. Charity care, separated into Hill-Burton obligations and other, equals 4% and 3%, respectively. The University Hospital provides more care to the poor than other Arkansas hospitals. With respect to the percentage of gross revenues by source of payment, University Hospital attributes 21.5% to Medicaid and 31.4% to No Insurance, as compared to 4.5% and 8.3%, respectively, for all Arkansas hospitals.

Findings and Recommendations

The Task Force issued a number of recommendations as follows:

~ Regionalized Maternity Care and Care for Children Under Age Five

A regionalized system of obstetrical care should be developed to include delivery of care for uncomplicated pregnancies at local primary care centers and referral for high-risk patients to secondary and tertiary centers. This system should include both service delivery and education components.

For children, a regionalized referral system should be established with clinics serving infants and children on physician referral.

~ Medicaid Expansions

The Task Force, while endorsing the expansion of Medicaid, deferred issuing specific recommendations until cost projections are made. The Task Force, however, expressed interest in: adding the unemployed parents option; covering all income-eligible pregnant women; and raising the AFDC income level or payment standards.

~ Reimbursement for Health Services for the Indigent

It was recommended that an Indigent Care Trust Fund be established to reimburse providers for indigent care services. In looking at various sources of revenue for the fund, taxes on hospital net revenues or on insurance premiums were rejected. The Task Force endorsed strongly an eight cent tax on cigarettes, which would raise about $22 million. Funds could come from other sources, including general or county revenues, earmarked revenues from extensions of dog- and horse-racing seasons, or a state lottery.

Disbursements from the Indigent Care Health Fund should be targetted to those most in need, with special emphasis on mothers and children. A strict definition of reimbursable costs should be

established; bad debt arising from care to non-indigents should be excluded. To qualify for Trust Funds, a hospital would be required to provide a minimum level of charity care. Finally, the Task Force strongly recommends that Trust Fund monies be used for primary care as well as for reimbursing hospitals for charity care.

~ Establish an Arkansas Health Care Commission

The Commission would set policies affecting disbursements from the Indigent Care Trust Fund, and would conduct research on medical indigence issues. The Commission should not be involved in regulatory or rate-setting activities.

Reference Documents

Indigent Health Care
Report of the Arkansas Governor's Task Force on Indigent Health Care
November 1984
Draft

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COLORADO

Task Force/Commission

Colorado Task Force on the Medically Indigent

Date Established: January 1983
Date Expired: February 1984

Background and Purpose

The Task Force, sponsored by the Denver Fund for Health and Medical Research, was charged with investigating problems associated with financing health care for those who cannot afford it, because of poverty, lack of health insurance, or inadequate insurance coverage. Policy recommendations were prepared and submitted to the Colorado General Assembly.

Analysis

Medical indigency in Colorado is not attributable to poverty alone, but may arise from factors such as family income, family size, property, insurance status and medical bills. The Task Force defined medical indigency as inability to afford needed health care due to poverty, lack of insurance, or inadequate insurance coverage. The medically indigent issue brings to the surface two problems: the uninsured poor have less access to needed health services; and developments in reimbursement are lessening the ability of providers to deliver free or discounted care to the indigent.

The Task Force conducted a comprehensive survey of the Colorado population to determine the extent of the medical indigence problem. The survey revealed that about 238,000 persons with incomes below 150% of the federal poverty level were uninsured. Certain groups within this population were found to be at greater risk of being without insurance — Blacks and Hispanics, farm and blue collar workers, and residents of the Denver metropolitan area.

Further analysis of survey results yielded additional data. Over 40% of the uninsured poor were age 18 or younger. Almost 50% of employed persons did not have health insurance. While the perceived health status of the uninsured poor is similar to that of the insured poor, those who are uninsured use fewer health services, are less likely to have a regular source of care, and have less access to physicians.

The Task Force also studied existing programs that finance health services for the poor. Medicaid covers about 150,000 persons, but does not cover single adults, childless couples, or the working poor. The Colorado Medically Indigent (MI) Program expended approximately $35 million in general revenue funds in 1983-84, serving about 75,000 persons. Ninety percent of the money is shared equally between two hospitals — Denver Health and Hospitals and the University of Colorado Health Sciences Center. The remainder goes to hospitals and nursing agencies participating in the Community Maternity Program and to hospitals and clinics under contract to the MI program.

County governments finance health services for the poor, but there is wide variation between counties: county contributions for health services ranged from under $1 to $120 per capita.

Findings and Recommendations

The Task Force issued thirteen recommendations which can be grouped into four major categories:

- Expand Medicaid Coverage. The Task Force proposed that, by July 1, 1984 the state should add children under age 18 in two-parent families, medically needy pregnant women, and medically needy children under age 18. These eligibles should be offered all Medicaid services except institutional long-term care, mental health, and alcohol and drug abuse treatment. It is estimated that adding these targetted groups would cost a total of $15.1 million, with the state share at $8.1 million.

- Revise Medically Indigent Program Eligibility, Benefits and Administration. The state program should be expanded to cover basic health care to all persons at or below 150% of the federal poverty level after their insurance is exhausted. The program would include persons whose incomes fall below the poverty line, after medical bills and insurance premiums are deducted, and whose assets are within the limits allowed by Medicaid. Eligible persons would be expected to contribute to the cost of care through cost-sharing. Covered benefits would be similar to those provided under Medicaid, but excluding long-term institutional services, and including some additional primary and preventive services. Administration of the Medically Indigent Program should be the responsibility of the Medicaid Agency.

- Reorganize State-Funded Programs. The state should enroll children and pregnant women eligible for the Medically Indigent Program in primary care case management programs. It should enroll the chronically ill and disabled with a primary care provider responsible for supervising their care. The Task Force also would require all hospitals to provide a minimum amount of charity care, based on a percentage of either operating costs, gross revenues, or operating margin.

- Expand Employment-Based Insurance. The state should provide tax incentives for all employers to offer adequate health insurance, develop incentives for individuals to purchase insurance, and formulate a plan to purchase short-term health insurance for the unemployed.

Reference Documents

Colorado's Sick and Uninsured: We Can Do Better, Report of the Colorado Task Force on the Medically Indigent, January 1984

Volume 1: Task Force Final Report
Volume 2: Colorado Health Survey Final Report
Volume 3: Compilation of Staff Research Papers

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FLORIDA

Task Force/Commission

Florida Task Force on Competition and Consumer Choices in Health Care

Date Established: 1982
Date Expired: March 1984

Background and Purpose

The Task Force was established by the state legislature under Chapter 82-182, Laws of Florida. The original purpose of the Task Force was to determine the best method of controlling health care costs—by regulation or by competition in the marketplace. In 1983, the legislature amended the charge of the Task Force by directing the group to develop a comprehensive approach to the funding of medical care for the medically indigent and the medically needy.

Analysis

The Task Force chose a market approach to imposing economic discipline on Florida's market for hospital services, acknowledging that a likely result of utilizing price competition would be an increasing reluctance on the part of health care providers to provide free or charity care. This point was important because Florida did not have a medical needy component to its Medicaid Program or its indigent care statute. The Health Care Responsibility Act of 1977, was proving to be ineffective.

Findings and Recommendations

The Task Force made the following recommendations regarding indigent care in Florida:

- Expand the Medicaid Program.

  The Task Force, noting that the Florida Medicaid Program covers few of the optional groups, urged the inclusion of children in two-parent families that are below the current AFDC cash assistance level, and the coverage of families with unemployed parent(s) below the AFDC cash assistance level.

  The Task Force also recommended the adoption of a Medicaid medically needy program, with services limited to basic acute care.

- Establish a state medically indigent pool.

  A medically indigent care pool was proposed, to which all hospitals would contribute a specified percentage of their net patient revenues, counties would contribute a per capita amount, and the state would match county payments at a specified rate. The medically indigent pool would: reimburse hospitals for care to other-

wise uninsured persons who meet uniform income and asset standards; and serve as the non-federal match for the expansions in the Medicaid Program.

~ Raise or eliminate the $100 Medicaid ceiling on reimbursement hospital outpatient services.

~ Enhance the availability of private insurance.

This would be accomplished by modifying the State Comprehensive Health Association Act to provide for income-tested premium subsidies from the medical indigency pool, and by extending insurance coverage with continuation requirements of up to 90 days.

~ Increase the return from state Medicaid expenditures.

This goal, to be pursued over the next 2-5 years, would be met by: enrolling a high proportion of the Medicaid-eligible population into a prepaid, capitated case management system; moving the Medicaid program toward a prudent purchaser system; and, transferring clients from state-funded programs to Medicaid.

~ Conduct a study on indigent care.

The Department of Health and Rehabilitative Services, in conjunction with other public and private groups, should undertake a careful analysis of the plight of the indigent, medically indigent and others unable to afford health insurance in Florida.

Policy Outcomes

During the 1984 session of the Florida Legislature, Senate Bills 176 and 679 were adopted as Chapter 84-35, Laws of 1984. Many of the Task Force's recommendations on indigent care were adopted by the legislature, including:

~ Expansions in Medicaid Eligibility

Effective July 1, 1985, the Florida Medicaid Program will expand eligibility to three groups: (1) AFDC-Unemployed families; (2) children under the age of 21 in an intact family; and (3) financially eligible married pregnant women.

Effective July 1, 1986, the state will establish a Medicaid medically needy program providing all services to which the categorically eligible are entitled, with the exception of long-term institutional services.

~ Creation of the Public Medical Trust Fund

The Fund will be financed by an annual assessment on hospitals of 1% of their net operating revenues (this assessment increases to 1.5% for the second and succeeding years), and by an annual state

appropriation of $20 million. This fund will finance the expansions in Medicaid eligibility. However, up to $10 million can be used to establish primary care programs for low-income persons through county public health units.

~ Increase in the Hospital Outpatient Cap

The hospital outpatient services cap is increased from the $100 limit to $500 per person.

~ Further studies on indigent care

The Hospital Cost Containment Board will contract with the state university system to conduct a study of:

1. The extent to which bad debts in Florida hospitals are due to the provision of care to the medically indigent;

2. Current methods of financing indigent care, including ad valorem taxes and state taxes; and

3. Proposals for broader-based funding sources for indigent health care.

In another study, the Department of Health and Rehabilitative Services will determine the feasibility of using the Public Medical Trust Fund to reimburse hospitals for inpatient and outpatient services provided to qualified medically indigent patients, including the non-resident poor. To qualify as medically indigent, the individual must be uninsured and below 150% of the federal poverty level.

Reference Documents

An Opportunity for Leadership, report and recommendations of the Florida Task Force on Competition and Consumer Choices in Health Care, March 1984.

Resource Person

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GEORGIA

Task Force/Commission

Joint Hospital Care for the Indigent Study Committee

Date Established: August 1984
Expiration Date: December 1, 1984*

*One of the Committee's recommendations is to continue the Committee past its termination date in order to resolve the indigent care problem.

Background and Purpose

The Committee was established under House Resolution 708 to study: (1) care for the medically indigent, and (2) the sale of public hospitals to private concerns. Numerous hospitals in Georgia had expressed to the legislature concern over their financial distress which they felt was partially due, to charity care.

Findings and Recommendations

The Committee has developed seven recommendations for consideration by the legislature during its 1985 session. They are:

- expand Medicaid coverage within, both the categorically needy component and the newly created medically needy program;
- establish a medically indigent pool to be funded jointly by the state, hospitals and counties. This pool may be used to finance expansions in Medicaid eligibility and to reimburse hospitals for charity care;
- require uniform reporting by hospitals and counties of bad debts and charity care;
- refine Act 1300, which requires hospitals operating emergency services to provide the appropriate, necessary emergency care to any pregnant woman who presents herself in active labor;
- whenever possible, make funds available to existing public health programs (e.g., maternal and infant care, Medically Indigent High-Risk Pregnancy Program, pre- and post-natal care for infants);
- re-establish the Committee for as long as is necessary to resolve the indigent care problem; and
- hire a consultant to further study the indigent care issue.

Reference Documents

Joint Hospital Care for the Indigent Study Committee Report, January 1985.

Resource Person

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INDIANA

Task Force/Commission

Governor's Select Advisory Commission on Public Welfare
Date Established: July 1983
Date Expired: November 1984

Background and Purpose:

The Commission was established by House Enrolled Act 1317 (P.L. 376-1983) to consider, review, and evaluate all issues relating to the continuing shift of responsibility for public welfare programs from the federal to the state government. The Commission was comprised of members appointed by the Governor, Speaker of the House, and President Pro Tem of the Senate assisted by a Resource Panel representing state executive agencies and county welfare boards. Early in the Commission's deliberations, three priority areas were identified: State Administration, Health Care for the Indigent, and Income Support Programs.

Analysis

The Commission reviewed the current status of health and welfare programs including Medicaid and Hospital Care for the Indigent. The Hospital Care for the Indigent program pays for emergency treatment of a disease, defect, injury, or deformity. The program covers resident and non-resident care in Indiana hospitals. Eligibility is based on income and resource standards that reflect standards of the AFDC program. A hospital providing services is required to file an application with the county Welfare Department. The program is financed entirely from county funds.

Program expenses have been rising at a dramatic rate, totalling $30.1 million in FY 84, and have become a serious financial burden to a growing number of counties. Rising costs, together with increased reluctance of county councils to adequately fund the program because of a limited property tax base, has placed many counties in financial jeopardy.

The Commission also studied funding patterns for welfare programs, especially the budget process at the county level.

Findings and Recommendations

The Commission issued a series of recommendations; those that apply to indigent care and health programs include:

Hospital Care for the Indigent

- set income eligibility standards initially at 60% of Medicaid, with bi-annual review.
- revise service definition to specify a definition of an emergency.

- develop statewide administration to include a system for data collection.

- establish a utilization review system.

- provide immunity to providers in the determination of service eligibility.

- specify that counties are to remain liable for their past debts.

- reaffirm that county/state funds are the payer of last resort.

Income Support

- revise AFDC by adopting the Unemployed Parents option.

- remove the rateable reduction, consolidate the Standard of Need, and lift or remove the maximum payment ceiling.

Funding

- counties should continue to share in the costs of welfare programs.

- county future financial obligations should increase at an annual maximum level defined as the rate of increase in the general property tax levy for each county general fund or the allowable tax levy growth rate, whichever is lower.

- beginning January 1986, state government should assume all costs above the ceiling established for each county.

- statutory authority for bonding to meet welfare obligations should be repealed.

Comments (Not Recommendations)

- study the adoption of a medically needy program for Medicaid.

- consider establishing a comprehensive data collection center for information relating to who is receiving public assistance, from what source, and amount.

Reference Documents

Report to the Governor
Governor's Select Advisory Commission on Public Welfare
November 30, 1984

Resource Person

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KENTUCKY

Task Force/Commission

Commission on Financing Health Care for the Medically Indigent; staffed by the Legislative Research Commission.

Date Established: October 23, 1984

Background and Purpose

During the 1984 state legislative session, several indigent care bills were introduced (most notably, a bill which would have required all hospitals to provide a fair share of charity care); however, none passed. Senate Concurrent Resolution 6, which established the Commission, was adopted. The Commission's tasks are to: study the financing of health care for the indigent; determine the number and the place of residence of persons who are underinsured and uninsured; examine Medicaid's eligibility restrictions: and determine the amount of uncompensated care provided by hospitals, physicians, and other providers.

The Commission must present a report to the Legislative Interim Joint Committee on Health and Welfare by August 1, 1985. Kentucky's next legislative session begins January 1986.

Resource Person

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MARYLAND

Task Force/Commission

Special Joint Committee on Health Care for the Uninsured;
Maryland General Assembly

Date Established: May 1983
Date Expired: December 1983

Background and Purpose

In May of 1983, the President of the Senate and the Speaker of the House appointed a committee composed of legislators to examine the problem of the uninsured. At the same time, the U.S. Congress was considering proposals for the provision of health insurance to the unemployed.

Analysis

The committee's deliberations centered on the federal proposals, and on estimating the need for and the cost of providing health insurance for the unemployed. Hearings were held across the state.

Findings and Recommendations

The Joint Committee report listed a series of recommendations, including the following:

- Maryland should not implement an unemployed health insurance program at this time;
- it should legislate a continuous open enrollment period for employees to initiate family coverage or convert from individual coverage to family coverage if a spouse becomes unemployed due to lay-off; and
- it should encourage outreach activities aimed at educating the unemployed about resources available to meet their health care needs.

Policy Outcomes

During the 1984 legislative session, the Maryland General Assembly adopted House Bill 908, which provides continuous open enrollment for the purpose of allowing a married employee enrolled under a group health insurance contract to alter the terms of his/her coverage to include the employee's spouse or children if the spouse loses coverage due to involuntary termination. Notification of the desired change must be made within six months of the termination of the spouse's coverage.

Resource Documents

Report of the Special Joint Committee on Health Care for the Uninsured, December 1983

Resource Person

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NEBRASKA

Task Force/Commission

Statewide Health Coordinating Council (SHCC) Task Force on Indigent Care
Date Established: June 1984

Background and Purpose

The Task Force was established to perform the following tasks:

- determine the effects on the provision of indigent care from the sale of a non-profit hospital to a for-profit corporation;
- estimate the magnitude of the indigent medical care problem in Nebraska; and
- identify and assess strategies for alleviating the indigent care problem.

The Task Force will complete these tasks by February 1985. At that time recommendations will be submitted to the Governor and the legislature.

Reference Documents

Health Care for the Medically Indigent: A Review of State and National Literature

Division of Health Systems Planning
Department of Health
Lincoln, Nebraska
September 1984

Resource Person

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NEW MEXICO

Task Force/Commission

1) Health Care Cost Containment Task Force
   Medically Indigent Work Group
   Date Established: July 1984

2) Statewide Health Coordinating Council
   Health Care Access Financing Committee
   Date Established: May 1984

Background and Purpose

The two organizations listed above were formed to address the medically indigent issue in response to a study funded by the State Health Planning and Development Bureau entitled, "Health Care Coverage and the Medically Indigent in New Mexico."

Analysis

The aforementioned study contained the following findings:

- Less than 60% of the state's population have private health insurance and 21% have neither private nor public health insurance. The study found that the absence of health insurance varied by population characteristics. For example, 25% of persons under the age of 18 lack coverage, as do 27% of persons between the ages of 18-44, 32% of Hispanics, 34% of individuals with annual incomes of less than $5,000, and 27% of those individuals residing in rural areas.

- Seventy-five percent of individuals with private health insurance obtain their insurance through their places of employment. Coverage varies by type of employment, with agriculture, construction, and mining exhibiting a much lower rate of coverage than government, transportation and manufacturing.

The report also surveyed the existing governmental programs that provide medical care to the medically indigent. Eleven of thirty-three counties currently levy a gross receipts tax of 1/4 percent to pay for their resident indigents. The University of New Mexico Hospital provides indigent care, with Bernallilo County providing $6.9 million in 1983. The University can also tap the state financed "out-of-county indigent funds" that covers the cost of hospital services to state residents outside of Bernallilo County.

Other sources of medical care for indigents include approximately 20 primary care clinics located through the state and charity care provided by hospitals under the Hill-Burton requirements. The clinics which are community Health Centers or National Health Service Corps. sites, receive some federal funding, however a substantial share of the costs are covered by state and local governments.

Findings and Recommendations

The entities studying the indigent care problem have developed joint preliminary recommendations. First, Medicaid program coverage should be expanded to include optional categories of eligibles including "Ribicoff" children under age 19, AFDC unemployed parents, and a Medically Needy program for pregnant women and children.

Second, a catastrophic health insurance pool should be created. Counties, responsible for indigent care under the Indigent Hospital Claims Act, would be able to draw funds from the pool. To be eligible for funds, counties would have to meet a maintenance of effort requirement by operating an existing indigent hospital claims fund and a targetted prevention program.

Reference Documents

Health Care Coverage and the Medically Indigent in New Mexico
Bureau of Business and Economic Research
University of New Mexico
February 1984
(available from the State Health Planning and Development Bureau)

Resource Person

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State Health Planning and Development Bureau
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Santa Fe, NM 87504
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NORTH CAROLINA

Task Force/Commission

Legislative Commission on Medical Cost Containment, staffed by Legislative Services Office.

Date Established: July 1983

Background and Purpose

The Commission is charged with exploring various cost containment strategies and related issues. The Commission has recently turned its attention to the indigent care issue, and will develop recommendations before the Commission expires at the end of 1985.

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OHIO

Task Force/Commission

Governor's Commission on Ohio Health Care Costs
Date Established: May 1983
Terminated: July 1984

Background and Purpose

The Commission was charged by the governor with recommending strategies for more efficiently using state resources for health care services.

Analysis

The Commission estimated that during 1982 Ohio's medically indigent received approximately $250 million of health care services.

An Ohio Hospial Association survey of hospitals indicates that Hill-Burton obligations constituted less than 15% of all uncompensated care.

The Commission made two assumptions: that the medically indigent will continue to need services, and that the state cannot afford to fund any new initiatives. Within these constraints the Commission considered four options: increased general tax support; premiums or other user taxes; all-payer hospital rate setting; and distributing the responsibility among institutions.

Findings and Recommendations

The Commission recommended the establishment of a "care or share" program to spread the burden of the cost and volume of indigent care across all competing institutions. The program should adhere to the following set of principles:

- each hospital is to be responsible for the same percentage of uncompensated care as is provided for insured persons, adjusted for the complexity of the case;
- preadmission, concurrent used to assure that services are necessary; and retrospective utilization review mechanisms should be under the program;
- each hospital's actual resource use would be estimated by computing the case mix for both compensated and uncompensated cases;
- the amount of payment or revenue for uncompensated care would be set at each hospital's prospective rate; and
- actual payment for uncompensated care would be limited to no more than the full cost for the highest cost facility providing a disproportionately large share of the community's care.

Reference Document

Governor's Commission on Ohio Health Care Costs:
Final Report
July 1984

Resource Person

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OKLAHOMA

Task Force/Commission

House Committee on Human Services
Indigent Health Care Hearings

Date Established: September 1983
Date Expired: December 1983

Background and Purpose

During the interim period between the 1983 and 1984 legislative sessions, the House Committee on Human Services examined the existing providers of health care for the indigent. The major providers included private hospitals, teaching hospitals and the Medicaid program.

Analysis

During the fall of 1983, numerous individuals representing a broad array of health care providers -- hospitals, physicians, state agencies, mental health representatives, nurses and others -- appeared before the House Committee in a series of hearings on indigent care.

Findings and Recommendations

Internal negotiations resulted in a legislative proposal, House Bill 1802, which was adopted. A report was not issued by the committee.

Policy Outcomes

HB 1802 was enacted as the Oklahoma Indigent Health Care Act. The Act provides state funding for those hospitals located in participating counties. To participate, a county must establish an indigent health care trust board or trust fund, and finance the fund by a 3.5 mill tax levy on assessed property (or raise an equivalent amount by other means).

Hospital claims deemed by the state to be valid shall receive payment based on the ratio of each hospital's annual indigent hospital care charges for eligible patients to the total amount of annual indigent hospital care charges for all participating hospitals in the state. The law defines an indigent as an individual who:

1. has insufficient income (equal to or less than the poverty level); and

2. lacks third-party coverage for necessary hospital services; or

3. has a catastrophic injury or illness that results in medical costs exceeding 50% of the individual's gross annual income.

A companion piece to HB 1802, House Joint Resolution 1051, was submitted to the voters for their approval. HJR 1051 proposed allowing counties to levy an ad valorem property tax of 3.5 mills for the financing of the county

indigent trust fund. (The state constitution places a limit on the amount a county may tax, and many counties are near that limit.) The electorate voted not to adopt HJR 1051. Although this outcome makes financing the county indigent trust fund more difficult, it does not invalidate the Indigent Health Care Act.

Reference Documents

No report was published by the House Committee on Human Services.

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SOUTH CAROLINA

Task Force/Commission

A coalition of state executive and legislative groups was formed in order to address the indigent care issue. They include: The Joint Legislative Committee on Health Care Planning and Oversight, the House Medical, Military, Public and Municipal Affairs Committee, the Senate Medical Affairs Committee and the Governor's Office.

Date Established: 1982

Background and Purpose

The coalition was organized in early 1982. In order to better understand the issues of the medically indigent problem, the State Health Planning and Development Agency conducted a study to define the problem and identify the effects of expanding Medicaid eligibility. The report identified several areas of policy expansion that should be studied further.

Based, in part, on the State Health Planning and Development Agency study of 1982, the Governor's Office of Health and Human Services proposed the adoption of a Medically Needy program. This proposal resulted in the commission of a major legislative study for the Health Care Planning and Oversight Committee of the General Assembly. The Medically Indigent Study was released in March of 1984. A legislative Ad Hoc Committee reviewed the Medically Indigent Study (referred to as the Toomey report), and in turn, released its own report in May of 1984.

All of these reports identified alternative policies to reduce the magnitude of the hospital charity care burden, expand Medicaid eligibility and create a state medically indigent program.

Analysis

In response to the Governor's proposal, the Joint Legislative Committee on Health Care Planning and Oversight commissioned a study of the entire medically indigent problem. During the course of the "Medically Indigent Study" (March 1984), a survey of South Carolina hospitals was done to determine medical indigency criteria, the amount of charity care provided, and the source of funds used to cover the charity care.

Other organizations were surveyed. Counties were asked to provide information on their financial contributions to medically indigent care. State agencies were contacted for information on state expenditures on medically indigent care. Finally, a survey of 16 hospitals (representing half the state's supply of beds) was conducted, for the purpose of reviewing indigent patient admissions during a four-week period.

Findings and Recommendations

The Medically Indigent Study, March 1984 (the "Toomey Report")

The report contained three broad categories of recommendations:

- expand Medicaid eligibility with the creation of a Medically Needy Program (the Governor's proposal) that targets pregnant women and children;
- establish a medically indigent fund to reimburse hospitals for indigent care ; and
- adopt general cost containment measures (such as DRG reimbursement for hospitals under Medicaid) that would control unnecessary and inappropriate admissions and care.

Report of the Ad Hoc Committee

The Ad Hoc Committee Report to the Medically Indigent Subcommittee of the Joint Legislative Committee on Health Care Planning and Oversight, was issued on May 6, 1984.

The Ad Hoc Committee developed three types of recommendations: Overall policy, guiding principles, and specific recommendations.

Overall Policy

- The complexity of the medically indigent problem necessitates a coordinated, multi-faceted approach to its solution; and
- an oversight committee should be established to monitor implementation and refinement of efforts to address the medically indigent problem.

Guiding Principles

- access to necessary health services must be maintained or improved
- adequate funding should be provided
- incentives for cost-effective delivery of care should be established
- responsibility for financing and providing indigent care should be shared; and
- consumers, employers, government, insurers, and providers all must accept responsibility in formulating a health care system that evolves from a regulatory model toward a competitive model.

Specific Recommendations

- adoption of a Medicaid Medically Needy Program;
- expansion of the basic Categorically Needy component of the Medicaid Program (by increasing the standard of need under the AFDC program and creation of an AFDC-unemployed program); and
- establishment of a state medically indigent pool.

The report also encouraged cost containment measures such as a DRG payment system for Medicaid, enhancement of health promotion/health education programs, and creation of a data base on medical indigency.

The legislature is currently working on a bill that would create a medically indigent fund.

Policy Outcomes

The state of South Carolina has established a limited medically needy program for pregnant women and "Ribicoff" kids — children under the age of 18 from intact families.

Resource Documents

The Medically Needy/Medically Indigent Problem in South Carolina: The Identification of Additional Medicaid Match Dollars. (1982) by the State Health Planning and Development Agency.

Medically Indigent Study (March 1984) by the Toomey Company, Inc. for the Joint Legislative Committee on Health Care Planning and Oversight.

Report and Recommendations (May 1984) by the Ad Hoc Committee of the Medically Indigent Subcommittee of the Joint Legislative Committee on Health Care Planning and Oversight.

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SOUTH DAKOTA

Task Force/Commission

The Interim Committee on Health and Welfare of the South Dakota state legislature conducted a study of the problem of indigent care.

DATE ESTABLISHED: Summer 1983

Findings and Recommendations

In December 1983, the Committee submitted to the Legislative Executive Board recommendations to do the following:

- establish a county catastrophic poor relief fund;
- define residency in order to clarify which county is responsible for the health care costs of an indigent;
- define medical indigency;
- establish an assigned health insurance risk pool.

Policy Outcomes

These recommendations become legislative proposals that were considered in the 1984 legislative session. All were passed with some amendments; however, legislation for the assigned risk pool (SB 12) was vetoed by the governor. The veto was not overridden.

House Bill 1015 requires counties to establish standards of indigency, while HB 1020 specifies that the indigent individual's county of original residence is responsible for reimbursement during the first 60 days of a treatment period, starting the day an indigent leaves the county in order to seek health care in another county.

HB 1021 established the catastrophic county poor relief fund. Participating counties incurring hospital and other medical claims in excess of $20,000 for any individual eligible for county poor relief may receive reimbursement from the fund at 90% of costs in excess of the $20,000 threshold. The state initially will provide $500,000 for the fund. At the end of the year the fund will be totally financed by an assessment on participating counties in an amount that replaces funds expended during the year.

Each participating county's assessment is based on the county's percent of the total population, minus individuals eligible for Medicaid, and the percent of taxable value of the participating counties as determined by the department of revenues. Each county's assessment shall be calculated by multiplying the average of the two factors by the total assessment. A key provision of the law required at least 50 counties (out of 66) to agree to participate by November 1, 1984 for the law to become effective. This requirement was met.

Resource Person

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TENNESSEE

Task Force/Commission

Governor's Select Committee on Health Care Cost Containment

Date Established: April 1984
Expiration Date: December 1984

Background and Purpose

The Committee was appointed by the Governor, Lieutenant Governor and the Speaker of the House to examine health care cost containment. During the Committee's deliberations, the indigent care was added to the agenda as a collateral issue because "the more we move to a competitive environment, the more apparent it becomes that nobody competes for the indigent."

Analysis

Tennessee contracted for a study on health care costs and access to health services. The contract included a survey of 900 Tennessee households having at least one family member without health insurance coverage, an extensive review of hospital data, and case studies of twelve hospitals. The Committee has received the following preliminary results of the study:

- Loss of health insurance is related to employment — Eighty percent of the households surveyed had health insurance in the past, but had lost coverage. Sixty percent of these lost coverage for reasons attributable to employment (e.g., changing jobs, layoffs, etc.)

- The health status of uninsured Tennesseans is similar to that of the United States population in general.

- Uninsured individuals experience barriers to hospital care. Forty-five percent of the uninsured persons who were advised by physicians that they needed hospital services never entered the hospital. Eighty-three percent of these persons stated that they did not follow their doctors' orders because they perceived costs to be too high.

- Uncompensated outpatient services are a problem. It is estimated that in FY 1983-84, uncompensated outpatient department services totalled $31 million.

- As is the case nationwide, the bulk of uncompensated care is concentrated in a few hospitals. Bad debt and charity care, excluding contractual allowances, totalled $217 million. Forty-two percent of this amount was incurred by five hospitals, predominantly urban teaching institutions.

- Tennessee is experiencing substantial numbers of people crossing county and state boundaries to receive care.

- It appears, based on case studies, that hospitals are limiting the amount of charity care provided. This is accomplished by not admitting non-emergency patients who do not have a source of payment or by dropping services that are major entry points for charity care patients (e.g., obstetrics).

- A large portion of uncompensated care is currently financed by cost-shifting between payors.

- According to a review of hospital data, it appears that the uncompensated care problem was no worse in 1982 than in 1978. However, due to the emergence of competitive forces in the health care market, cost-shifting is a less viable alternative for raising revenues to cover uncompensated care. For this reason, hospitals are looking at the future of indigent care much differently than in the recent past.

Findings and Recommendations

The Committee will issue a final report in December 1984.

Reference Documents

Analysis of Health Care Options in Tennessee: Uncompensated Care
Health Policy Center
Institute for Public Policy Studies
Vanderbilt University
Preliminary Draft prepared under contract to Tennessee Department of Health and Environment

Resource Person

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TEXAS

Task Force/Commission

Task Force on Indigent Health Care
Established: September 1983

Background and Purpose

The Governor, Lieutenant Governor, and Speaker of the House appointed the Task Force on Indigent Health Care to study medical indigency in Texas and to address four main issues: scope of services; eligibility criteria; administrative structure; and methods of finance.

The Task Force is comprised of 71 members representing elected officials, physicians, medical school faculty, hospital administrators, advocacy groups, business, labor, and state health agencies. The elected officials serve as the Executive Committee, which is the decision-making body of the Task Force.

Analysis of the Problem

The Task Force, for purposes of analysis, separated the indigent care issue into six major components:

- Who are the Medically Indigent?

  Medical indigency is the absence of public or private insurance coverage to help pay for health care services. Based on this definition, the Task Force cited a 1981 survey finding which found that about 28% of the poverty population had no public or private health insurance coverage. The survey also found that, of persons having an income of less than 25% of poverty guidelines, 46% are uninsured. Further, of the population in poverty and without insurance, 60% are female, 50% are Hispanic, and 22% are Black.

  According to a recent poll, at least one family member was uninsured in about 26% of the families in which the head of the household was unemployed, compared to 19% for blue collar families and 10% for families identified as professional or management.

- The Problem of Uncompensated Care

  The Task Force noted that there is no truly uncompensated care because the cost is passed on to local taxpayers, other patients, or insurance programs. Uncompensated care can be separated into three components: charity care to persons eligible for free services; bad debt which covers the care provided to patients who either do not choose to or are unable to pay for services received; and contractual allowances defined as the difference between hospital charges and the rate reimbursed by third-party payors.

Preliminary results of a survey of all nonfederal, nonpsychiatric, general acute care Texas hospitals, indicate that 24% of total gross hospital revenues are classified as uncompensated. Thirty-six percent of uncompensated care represents charity care.

~ The Role of Public Hospitals

The uncompensated care burden falls disproportionately on certain types of hospitals. Public hospitals provide almost 90% of total charity care reported. Private hospitals, which by Texas statute are required to provide emergency services only without regard for ability to pay, offer less than one percent of charity care reported in 1983. In addition, charity care falls most heavily on hospitals in major metropolitan counties (66%), while hospitals in rural areas account for less than one percent of charity care.

~ Ambiguous and Varying Local Government Responsibilities for the Medically Indigent

The Report stated that "county responsibility for indigents is one of the most difficult and important issues under consideration by the Task Force." Texas law does not provide specific guidelines concerning who is indigent and what services must be provided to them. The Texas Constitution and statutes authorize counties to care for the indigent and poor. As a result, practices vary from county to county. The courts have stepped into this void as a result of lawsuits brought to establish county standards for indigent medical care and lawsuits between counties to recover expenses for nonresidents.

In addition to general responsibility, counties having a county hospital must meet formal requirements for the provision of indigent care. Hospital districts assume the county responsibility for providing medical and hospital care to needy residents.

Preliminary results of a survey of Texas counties indicate that two-thirds of the state's population reside in counties that have county hospitals and, thus, have clear responsibilities to provide indigent care, though eligibility and amount of service vary. However, about 40% of the poverty population reside in counties where responsibility is less clear,including 36 counties where there is no hospital, and 97 counties without a public hospital. As a result of these variations, there is uneven access to care, differences in types of services, and uneven local tax efforts.

~ The Role of the State in Indigent Care

Almost all of the state's indigent care contained in the three departments responsible for health, welfare, and rehabilitation. Taken together, they receive 18.4% of total state general revenue appropriations. For purposes of comparison, education received the greatest percent of appropriations -- 61.2%

~ Continued Problems of Access in a Changing Environment

The demographic characteristics of the Texas population have exacerbated the problems associated with indigent care in different regions of the state. Minority groups have a disproportionately high incidence of disability and are less likely to have insurance coverage. The bulk of the Hispanic population resides in the South Central and Gulf regions, while the Black population is concentrated in the Southeast and North Central areas.

Regional economic differences also contribute to the problem. Because of the slump in the oil economy, the coastal region has experienced high levels of unemployment. Unemployment in the Plains region has increased due to falling agricultural production, and the devaluation of the peso has contributed greatly to economic problems along the border where 30% of the population live in poverty.

Findings and Recommendations

The Task Force issued a total of 47 recommendations dealing with a wide range of alternatives, including prevention and promotion, mental health, primary care, and catastrophic insurance coverage. Specific recommendations concerning Medicaid, local responsibility, maternal and child health care, and the role of hospitals are:

~ Expand Medicaid coverage to new groups of eligibles

Currently, the Texas Medicaid program enrolls about 25% of the poverty population, compared to 53% nationwide. The Task Force supports developing a medically needy program for children and pregnant women increasing the AFDC payment level, and adding an unemployed parents program for both categorically and medically needy.

~ Clarifying local responsibility

The Task Force recommends adopting a statewide definition of medical indigency to include persons with incomes below 100% of federal poverty levels. Minimum and maximum standards of responsibility should be adopted.

Minimum standards should include: eligibility for persons not otherwise covered and who meet Medicaid income eligibility limits, and coverage of primary, secondary, and tertiary care costs. Maximum liability standards should address out-of-county care, limit payment to Medicaid rates, limit hospital care to either 30 days or $30,000 per year per recipient, set a total expenditure cap equal to 10% of general revenue, and require maintenance of current effort.

~ Maternal and Child Health

Maternity service is the top priority service for indigents. The Task Force recommends: a full range of maternity services including prenatal care, family planning, screening, and dental services; additional availability of prenatal care to underserved areas; creation of a system to care for high-risk prenatal patients and to monitor high-risk infants; and an emphasis on adolescent pregnancy prevention.

~ The Role of Hospitals

The Task Force recommends the adoption of a fair-share formula to distribute the indigent care burden across hospitals by requiring hospitals to either provide care or contribute funds to an indigent care pool. It is also recommended that hospitals make a commitment to provide a minimum level of indigent care as a condition for certificate of need approval. Finally, mandatory hospital reporting and accounting requirements for indigent care data should be established.

Policy Outcomes:

The state has extended as Medicaid eligibility to the optional categorical groups of pregnant women and children under age 18, as permitted under federal law.

Reference Documents:

Preliminary Report
Task Force on Indigent Health Care, September 1984

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UTAH

Task Force/Commission

The Governor's Task Force on Financial Barriers to Quality Health Care in a Competitive Environment.

Date Established: August 1983

Background and Purpose

The Governor charged the Task Force with studying financial barriers to quality health care, with special emphasis on the impacts on the state's competitive market policy. Task Force participants represented the executive and legislative branches of state government, providers, purchasers, and consumers.

The Task Force sought to identify financial obstacles to health care access, such as the effect of price competition on access by the poor, and the problems experienced by individuals and families subject to catastrophic medical expenses.

Analysis

The Task Force based its analysis on national data extrapolated to Utah in order to identify those with inadequate medical care coverage. Using this method, the Task Force identified three categories of indigence: persons having low incomes; elderly persons whose incomes are insufficient to meet their medical needs which are not covered adequately by Medicare; and ethnic and racial minorities, especially Hispanics and Blacks. While the Task Force did not develop data specific to Utah, the relationship between employment and insurance was reviewed extensively, based on national surveys and analysis.

Findings and Recommendations

Based on the principle that all citizens should have access to a minimum level of health care regardless of their ability to pay, the Task Force issued a lists of recommendations, summarized below:

- The existing state medically indigent program should become statewide, state-administered, and state-funded.

  At present, Utah has an Indigent Medical Assistance Program which counties can choose to join, at their option. The program provides county and state matching funds for medical services provide in emergency or life-threatening situations for those persons unable to pay for such care. Currently, sixteen of the 29 counties participate, within those counties approximately 76% of the state's population reside. Each county contributes an amount based on 1/4 cent of assessed valuation of property taxes, with the state paying for expenses over that amount.

- The state should insure that individuals have access to prenatal care.

- The state should incorporate cost-sharing programs that: discourage inappropriate use, would not discourage people from seeking needed medical services, and would vary according to ability to pay and that would be cost-effective.

- The Department should review the feasibility of a recovery system in which persons who have received state-funded care can repay the state when they are no longer indigent.

- The state should be encouraged to install a "health hotline" to provide information regarding available community health resources.

  The state should investigate the need for a catastrophic medical program, and identify alternative systems.

Policy Outcomes

The state has implemented the "Health Hotline" initiative, effective October 1, 1984.

The recommendation that the existing medically indigent program become statewide, state-administered, and state-funded has been accepted by the governor and included in the budget submitted to the legislature for approval.

Reference Documents

Report of the Governor's Task Force on Financial Barriers to Quality Health Care in a Competitive Environment
Draft
June 1984

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VIRGINIA

Task Force/Commission
Joint subcommittee studying indigent health care

Date Established: October 1984

Background and Purpose

House Joint Resolution 129, adopted during the 1984 session of the Virginia General Assembly, requests a legislative committee to study alternative indigent care programs. The resolution directs the committee to examine the long-term consequences of the existing programs and its alternatives.

Virginia has four indigent care programs, each with its own eligibility criteria and benefit coverage. The resolution was introduced in response to this fragmented indigent care system in Virginia and the growing indigent care burden of the two state teaching hospitals; which is the most expensive state indigent care program.

The resolution notes two other reasons for studying possible changes in the basic structure of Virginia's indigent health care delivery system. First, changing federal reimbursement policies for Medicare and Medicaid (from cost-based to prospective payment) will put greater pressure on the state indigent care programs and community hospitals. Along with trends toward marketplace competition (PPOs, HMOs and emphasis on providing care in the least-cost setting), hospitals will be less able to compensate charity care by charging paying patients with higher rates. This emphasis on cost is especially troublesome for the state teaching hospitals for they traditionally have a much higher level of indigent care and, due to their teaching function, have higher costs for providing medical care.

The resolution notes a second reason for the study: other states, such as Arizona, California and Florida, have been experimenting with non-traditional approaches for providing medical care to the indigent. The experiences of these states should be examined.

The Committee is to submit a report (with recommendations if deemed advisable) to the 1985 session of the General Assembly.

Resource Person

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WASHINGTON

Task Force/Commission

Ad Hoc Advisory Committee on Uncompensated Health Care

Date Established: 1983
Date Expired: January 1984

Background and Purpose

The Ad Hoc Committee was appointed to assist the Senate and House Ways and Means Committee and the Legislative Budget Committee to assist them in examining the problem of inadequate access to health care for those without third-party coverage. The Committee was requested to present recommendations to the legislature for consideration during the 1984 legislative session.

Analysis

The Committee identified four central concerns:

- The poor face increasing financial barriers to health care;
- There is an uneven distribution of the cost of uncompensated care among the state's hospitals which creates incentives to further limit access to care;
- Services utilized by the uninsured poor are expensive, and this may delay their decision to seek care; and
- Rising costs threaten the health care system as a whole and discourage attempts to provide greater access to care.

Findings and Recommendations

The recommendations of the Committee were based on five major principles:

(1) Responsibility for providing access to health care for those without financial means rests ultimately with the state.

(2) The state should ensure a just and fair distribution of the cost of health care for the uninsured poor.

(3) Proposed solutions should promote a restructuring of incentives to encourage appropriate utilization of health care services in cost-effective delivery systems.

(4) Solutions should contribute to long-term reductions in the rate of increase of health expenditures.

(5) Any interim solutions should advance the long-term goal of providing effective health care for the poor in a time of increasing financial constraints.

The Committee made two recommendations: (1) expand Medicaid eligibility; (2) and redistribute uncompensated care among Washington's hospitals.

(1) Medicaid Expansion

The Committee urged expansion of Medicaid to incorporate those who currently lack financial means to pay for needed health care. The Committee also encouraged the state Medicaid program to provide more care through managed health care systems (HMOs, PPOs, community clinic networks and hospital-based primary care networks).

(2) Redistribution of Uncompensated Care

The second basic recommendation was the development of an interim program — not to last more than 3 years — to distribute the uncompensated care burden more equitably among hospitals. The Committee offered two approaches in collecting and distributing the necessary funds:

- The first approach, favored by most Committee members, would reimburse hospitals for charity care, after patients' financial responsibility was determined by a sliding fee scale. The common fund would be financed by assessing a percentage of hospital revenues for uncompensated care what would be built into each hospital's payment rates (as established by the Washington State Hospital Commission). Each hospital providing uncompensated care would be reimbursed from the fund. Those hospitals providing higher than average levels of uncompensated care would receive more funds than they contributed.

- The second approach would be similar to the first, except that only a small subset of hospitals — "target hospitals" that provide a high level of charity care — would be able to draw from the fund.

Policy Outcomes

SB 4403, Chapter 288, Laws of 1984 amended the Washington State Hospital Commission Act in the following manner:

(1) Requires the Hospital Commission, in its annual report to the legislature, to include: data on the amount of charity care provided by each hospital; an analysis of the law's effect on the medically indigents' use of non-hospital settings; and an analysis of the law's impact on the resulting costs of the state's limited casualty program.

(2) Directs the Commission to establish, by rule, a definition of residual bad debt (for rate-setting purposes) and to adopt uniform criteria for identifying patients receiving charity care.

(3) Requires the Commission to compile data on charity care.

(4) Directs the Commission to assure that no hospital adopt admission practices resulting in a significant reduction in the proportion of patients who have no third-party coverage and are unable to pay, or a significant reduction in the proportion of individuals admitted for inpatient services for which payment is, or is likely to be, less than the charges for such services.

(5) Adds to the certificate of need approval process the consideration of a hospital's level of charity care as compared to the regional average.

(6) Allows the adoption of a hospital reimbursement mechanism that deals equitably with the costs of charity care.

Three charity care provisions of SB 4403 were vetoed by the governor:

(1) Permission for hospitals to charge any payor at a rate less than that approved by the Commission if the hospital provides charity care at or above the regional average.

(2) Requirement that hospitals provide emergency or other medically necessary services to any person.

(3) Mandatory rejection of a certificate of need application when a hospital has not met the regional average level of charity care.

Reference Document

Ad Hoc Advisory Committee on Uncompensated Health Care: Findings and Recommendations; January 12, 1984.

Resource Person

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WEST VIRGINIA

Task Force/Commission

Uncompensated Care Task Force

Date Established: November 1984
Date Expired: Has not been set

Background and Purpose

In response to proposed uncompensated care legislation that failed to pass, and in response to hearings before the West Virginia Health Care Cost Review Authority, a Task Force was formed by the Authority to examine the issue of uncompensated care and indigent care.

Members of the Task Force include legislators and representatives of the Review Authority, the hospital association, the Medicaid Agency, primary care clinics, legal services, and others.

The Task Force will examine the issue of uncompensated care in two steps. First, the Task Force will develop recommendations concerning the issue of uncompensated care provided by hospitals. These recommendations are to be drafted into legislative proposals for the 1985 session. The Task Force has been divided into three subcommittees, each with its own assignment: (1) definition of charity care; (2) development of program alternatives; and (3) development of funding alternatives.

The second phase of the Task Force is to address the long-term problem of indigent care. The group will study alternative solutions to the broader problem of indigent care, including uncompensated care provided by non-institutional providers. This of the Task Force's deliberations will begin after the West Virginia Legislature adjourns for the year.

Resource Person

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WISCONSIN

Task Force/Commission

Secretary's Advisory Committee on General Relief

Date Established: October 1983
Date Expired: July 1984

Background and Purpose

The Committee was appointed by the Secretary of the Wisconsin Department of Health and Social Services to develop recommendations for reforming the General Relief Program. It addressed a broad range of policy issues, including medical care for the indigent. The Committee was challenged to develop its recommendations in the context of severely escalating program costs and a widespread call for property tax relief.

Analysis

The General Relief program provides aid to individuals or families in need of basic living necessities, including medical care, who have no other resources. General Relief is financed primarily by local property tax revenues. The program is administered by local governments; in most cases counties, but cities, towns or villages, administer the program in 21 of the 72 counties.

In 1980, the average monthly caseload was 5,000 statewide, with total annual expenditures estimated at $16 million. By 1983, the monthly caseload had increased to 20,663 and expenditures increased to $45.15 million annually.

The medical relief benefits component of the General Relief program has increased from an estimated $8.3 million in 1980 to $19.17 million in 1983. Local officials are concerned about the medical component in particular, because medical costs are unpredictable and one claim can put a severe strain on a local government's budget.

In 1983, the state became involved financially provisions for in the General Relief program. The 1983-85 biennial budget contained provisions of state reimbursement of 10% of non-medical benefits, 10% of medical relief claims between $500 and $5,000, and 50% reimbursement for medical claims over $5,000.

A particular problem in the medical benefits component of the General Relief program is the legal settlement issue. Legal settlement is a reimbursement system that allows the entity granting General Relief to seek financial reimbursement from the recipient's place of residence. The existing system increases the administrative burden for localities and can create cash flow lags.

Findings and Recommendations

The Committee issued a number of recommendations for reform of the General Relief system. Those that apply to the medical benefits component include:

- It should be the goal of the state to make General Relief a 100% state-financed, county-administered system.

- Legal settlement should be abolished when General Relief becomes county-administered. A chargeback system should be developed the county of treatment to the county of last known address for the medical costs of treating General Relief recipients referred by a physician or county, and for the cost of treatment of either ongoing cases or eligible persons and ongoing cases, sent for treatment for medical emergencies.

- The state should develop uniform income and resource limits for eligibility determination.

- The state should phase in assumption of financing the for medical benefits component. In the first year, the state would reimburse 25% of individual claims up to $5,000, and 50% of claims above $5,000. In the second year, the state would reimburse 50% of individual claims up to $10,000, and 100% for those over $10,000.

- The Department of Health and Social Services should undertake a thorough study of the General Relief medical system.

Policy Outcomes

The Committee report and recommendations were submitted to the Secretary of the Department of Health and Social Services, for her consideration.

NOTE: There are other study activities taking place within the state government to address indigent care. The Department of Health and Social Services will study further changes in the General Relief program in the areas of administration and mandated benefits. The State Health Policy Council has recently established an ad hoc committee to investigate gaps in existing financing and delivery systems and to offer solutions to make recommendations. Finally, pursuant to state statute, the Department of Health and Social Services is required to develop a model state health insurance plan aimed at providing uninsured low-income persons with the opportunity to obtain health insurance. The department has contracted for a study to analyze the various alternatives.

Reference Documents

General Relief in the State of Wisconsin: Report and Recommendations of the Secretary's Advisory Committee on General Relief; June 28, 1984.

Resource Person

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Intergovernmental Health Policy Project
The George Washington University

The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 states. The Project provides assistance to state executive officals, legislators, legislative staff and others who need to know about important developments in other states. At the same time, the IHPP helps federal officals identify innovative state health programs and specific state problems.

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State Medicaid Information Center
The National Governors' Association
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